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Case No. 11-1973

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETER KINDER, *et al.*,
Plaintiffs-Appellants

v.

TIMOTHY F. GEITHNER, *et al.*,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MISSOURI

BRIEF *AMICI CURIAE* OF ECONOMIC SCHOLARS IN SUPPORT OF DEFENDANTS-APPELLEES[1] SUPPORTING AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

There is no corporation holding any ownership of the *amici*, who are a group of scholars specializing in the economics of the health care market.

Respectfully submitted,

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INTRODUCTION

The *Amici Curiae* submit this Brief in support of Appellees should the Court reach the merits of the case. On the merits, *Amici* urge the Court to uphold Congress' power under the Commerce Clause of the United States Constitution to enact section 1501 of the Patient Protection and Affordable Care Act ("ACA" or the "Act").[1] That section requires that, with certain exceptions, all Americans who can afford a minimum level of health insurance either purchase such insurance or pay a penalty to the United States Treasury.[2]

INTEREST OF *AMICI CURIAE*[3]

Amici Curiae are professors and scholars in economics who have taught, studied, and researched the economic forces operating in and affecting the health care and health insurance markets. The Economic Scholars include internationally recognized scholars in economics, including three Nobel laureates,[4] two recipients of the John Bates Clark Medal for the outstanding American economist aged 40

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[1] Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2] 26 U.S.C. § 5000A (minimum coverage provision).

[3] Counsel for Appellants and for Appellees have consented to Amici filing this Brief. No counsel for any party authored this brief in whole or in part, nor did any party, person, or entity other than *Amici* and their counsel, make a monetary contribution to the preparation and submission of this Brief. *See* Fed. R. App. P. 29(c)(5).

[4] The Nobel Laureates are Dr. Kenneth Arrow (1972), Dr. George Akerlof (2001), and Dr. Eric Maskin (2007).

and under,[5] and former high-ranking economists in a number of prior administrations. The *Amici* believe that reform of the health care system is essential to constraining the growth of health care spending and that broadly-based insurance coverage is essential to any reform of the health care system in this country.

This Brief describes the unique economics of the health care industry and explains the logical incoherence of assertions that a person can be "inactive" or a non-participant in the health care market. Virtually all Americans will, at some time during their life, require health care, either because of illness, accident, or the wear and tear of age. The extremely high costs of health care for all but the most routine treatments and procedures are beyond the means of all but the wealthiest Americans. Insurance is how we pay for our health care, and the requirements of section 1501 assure that all Americans who can afford it will contribute to the costs of their own health care by maintaining reasonable insurance coverage. Otherwise those costs will necessarily be borne by others who do buy insurance or by the taxpayers. As former Massachusetts Governor Romney noted when signing the Massachusetts equivalent of section 1501:

> Some of my libertarian friends balk at what looks like an individual mandate. But remember, someone has to pay

[5] The winners of the John Bates Clark Medal are Dr. Susan Athey (2007) and Dr. Matthew Rabin (2001).

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> for the health care that must, by law, be provided: Either the individual pays or the taxpayers pay. A free ride on the government is not libertarian.[6]

Amici also show why upholding section 1501 will not result in some vast expansion of federal power, and respond to the economic analysis advanced by the "*Amici* Economists in Support" in *State of Florida, et al., v. U.S. Department of Health and Human Services,*[7] and largely accepted by the Eleventh Circuit.[8] The data underlying that analysis are flawed, and the analysis fails to recognize that section 1501 is "an essential part of a larger regulation of economic activity . . ." designed to make health care insurance available to the vast majority of Americans.[9]

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[6] Mitt Romney, *Health Care for Everyone? We Found A Way*, WALL ST. J., Apr. 11, 2006, at A16, *available at* http://online.wsj.com/article/SB114472206077422547.html/mod=opinion_main_commentaries.

[7] *See* Brief for Amici Curiae Economists in Support of Appellees/Cross Appellants and Affirmance, Dkt. Nos. 11-11021 & 11-11067 (11th Cir. filed May 11, 2011) ("Amici Br.").

[8] *Florida v. Dep't of Health & Human Services,* --- F.3d ---, 2011 WL 3519178, Nos. 11-11021 & 11-11067 (11th Cir. Aug. 12, 2011) ("*Florida v. HHS*").

[9] *Mead v. Holder,* 766 F. Supp. 2d 16, 30 (D.D.C. 2010) (internal quotations omitted).

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ARGUMENT

The District Court dismissed Appellants' complaint on ripeness and standing grounds and did not reach the merits of the case. [10] On this appeal, Appellants challenge not only the District Court's procedural holdings, but also urge this Court to reach the merits.[11]

Amici are submitting this brief in the event the Court reaches the merits and to explain both the economic factors that make the provision of health care in the United States unique and how the provisions of section 1501 directly facilitate Congress' efforts to reform the health care market. Spreading the costs across the broad spectrum of those who will require health care is essential to any comprehensive regulatory framework for that market.

Appellants' argue, incorrectly, that the decision not to purchase health insurance is "inactivity," that Congress lacks the power under the Commerce and Necessary and Proper Clauses to regulate that decision, and that upholding section 1501 would usurp the power reserved to the States and the people by the Tenth Amendment.

Although the decision to forego insurance has the superficial appearance of "inaction," it is, from an economic perspective, nothing of the kind. It is an act

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[10] *Kinder v. Geithner*, --- F. Supp. 2d ---, No. 1:10-cv-00101, slip op. at 21 (E.D. Mo. Apr. 26, 2011).

[11] *See* Brief of Appellants at 39-45.

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that effectively shifts the burden of paying for inevitable medical problems to others, substantially affecting the cost of health care and the overall operation of the interstate health care and health insurance markets. Section 1501 is a tailored response designed to ensure that all who can afford it bear a share of the cost of the medical treatments they will inevitably need, rather than imposing those costs largely or entirely on others. As the Sixth Circuit Court of Appeals recently held:

> The activity of foregoing health insurance and attempting to cover the cost of health care needs by self-insuring is no less economic than the activity of purchasing an insurance plan. Thus, the financing of health care services, and specifically the practice of self-insuring, is economic activity.[12]

I. The Unique Economics of the Health Care Industry Make the Minimum Coverage Provision Necessary

Economists have long recognized that health care has unique characteristics not found in other markets. Indeed, health care violates almost all of the requirements for markets to yield first best outcomes ("Pareto optimality").[13] One requirement for market optimality is that people know what they need, and have full information about how to obtain it. With health care, by contrast, need is

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[12] *See Thomas More Law Ctr. v. Obama*, --- F.3d ---, 2011 WL 2556039, No. 10-2388, at *11 (6th Cir. June 29, 2011) ("*Thomas More Law Ctr. II*"); *accord Florida v. HHS*, 2011 WL 3519178, Nos. 11-11021 & 11-11067, at *83-117 (Marcus, J., dissenting); *Mead*, 766 F. Supp. 2d at 30; *Liberty Univ., Inc. v. Geithner*, 753 F. Supp. 2d 611, 633 (W.D. Va. 2010).

[13] Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, Am. Econ. Review, Dec. 1963, at 941-973; N. Gregory Mankiw, Principles of Economics (5th ed. 2009).

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unpredictable and information – particularly about the costs of treatment – is far from complete.

Moreover, optimality requires that individuals' actions affect only themselves. This is again not true of health care, where individuals' actions have effects far beyond themselves – both directly (by spreading communicable diseases, for example) and indirectly (by not being insured and thus shifting costs to others, for example).

Optimality in a market also requires vigorous competition on the part of providers. Because of substantial market imperfections in medical care, however, a variety of constraints are imposed on medical care providers, including licensing requirements and regulation of the provider-patient relationship. Structural factors in the markets for health care, such as the limited number of hospitals and primary care physicians, are also inconsistent with perfect competition. As a result of these market failures, economists do not approach the health care industry with the deference to individual choice or the expectations of optimality that they do in other markets.

These market failures are the foundation for the field of health economics and have been studied for decades. The paper that launched the field nearly a half century ago notes that

> [t]he failure of the market to insure against uncertainties has created many social institutions in which the usual assumptions of the market are to some

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extent contradicted. The medical profession is only one example, though in many respects an extreme one.[14]

That remains true today. Of particular relevance to this case, economists who have studied health care and health insurance for many decades have concluded that it is incorrect to say that people who do not purchase health insurance do not participate in or affect the markets for medical care and health insurance. Rather, all participate in the markets for medical services and necessarily affect the market for health insurance. This conclusion is based on three observations:

1. *People cannot avoid medical care with certainty, or be sure that they can pay for the costs of care if uninsured*

Everyone gets sick or suffers an injury at some point in life. When they do, they generally need and receive medical care. Sickness, and especially injury, is often unforeseen. People need medical care because of accidents, life situations beyond their control (*e.g.*, cancer, a mental health emergency), unexpected outcomes (*e.g.*, chronic care medications fail to stem a disease), or the normal aging process (*e.g.*, joint replacement, Alzheimer's disease, congestive heart failure). Thus, even if people do not intend to use medical care, they often end up using it anyway. According to the Medical Expenditure Panel Study, the leading source of data on national medical spending, 57 percent of the 40 million people

[14] Arrow, *supra* n.13, at 967.

uninsured in all of 2007 used medical services that year.[15] By another metric, even the best risk adjustment systems used to predict medical spending explain only 25 to 35 percent of the variation in the costs different individuals incur; [16] the vast bulk of spending needs cannot be forecast.

Moreover, because medical care is so expensive, essentially everyone requires funds beyond their own resources in order to afford it. In 2007, the average person used $6,305 in personal health care services,[17] which is over 10 percent of the median family's income that year and approximately 20 percent of the median family's financial assets.[18] Even routine medical procedures, such as

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[15] Agency for Health Care Quality and Research, Medical Expenditure Panel Survey, Summary Data Tables tbl. 1 (hereinafter AHQR Tables), *available at* http://www.meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2007&Table=HCFY2007%5FPLEXP%5F%40&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT07&VAR6=MSA&VAR7=REGION&VAR8=HEALTH&VARO1=4+17+44+64&VARO2=1&VARO3=1&VARO4=1&VARO5=1&VARO6=1&VARO7=1&VARO8=1&_Debug=.

[16] Ross Winkelman and Syed Mahmud, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment, Society of Actuaries (Apr. 20, 2007), *available at* http://www.soa.org/research/research-projects/health/hlth-risk-assement.aspx.

[17] Ctrs. for Medicare and Medicaid Servs., *Historic National Health Expenditure Data*, NHE Web Tables, *available at* http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage.

[18] Brian K. Bucks et al., *Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances*, Survey of Current Business, Feb. 2009, at A2-A56. Houses are not counted toward one's "financial assets."

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MRIs, CT scans, colonoscopies, mammograms, and childbirth, to name a few, cost more than many Americans can afford.[19]

Those suffering from many common, but costly, medical problems spend substantially more. For example, medical costs in the year after a colorectal cancer diagnosis average $25,000, even before expensive new medications;[20] pancreatic cancer treatment costs about $57,000;[21] and treatment of a heart attack for 90 days cost over $20,000 in 1998.[22] All told, ranking everyone on the basis of medical spending, including those who did not use any care, the costs for the top one percent of that distribution equaled $85,000 on average.[23] This amount is 46

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[19] The *Amici Economists* argue that these numbers overstate the medical expenses of the "young, healthy individuals" who are the target of the mandate. Amici Br., *supra* n.7, at 13. However, even the young and healthy incur medical expenses beyond the means of most Americans. For example, in 2008, the average in-hospital cost for a normal live birth was $7,933 with other physician expenses of $1,380. AHQR, *supra* n.15, at tbl. 3-A (2008 Mean Expenses per Person with Care for Selected Conditions by Type of Service), *available at* http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?Action=Search&SearchMethod=1&component=1&subcomponent=0&tableSeries=2&year=-1.

[20] K. Robin Yabroff et al., *Costs of Care for Elderly Cancer Patients in the United States*, J. of the Nat'l Cancer Institute, Apr. 29, 2008, at 630-41.

[21] *Id.*

[22] David M. Cutler and Mark McClellan, *Is Technological Change in Medicine Worth It?*, Health Affairs, September/October 2001, at 11-29.

[23] Kaiser Family Foundation, Trends in Health Care Costs and Spending (Mar. 2009), *available at* www.kff.org/insurance/upload/7692_02.pdf; AHQR, *supra* n.15.

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percent above median family income and nearly three times the financial assets of the median family. Indeed, this amount – $85,000 – exceeds the total financial assets of all but the very well-to-do.[24] Accordingly, it is very difficult for anyone to commit to paying for medical care on their own, and only the exceptionally wealthy can even consider doing so.

The combination of the uncertainty of need and the high cost of care when needed highlights the fundamental distinction that health economists make between health insurance and medical care. Medical care is the set of services that improve or maintain one's health. Health insurance is a mechanism for spreading the costs of that medical care across people – so that some people contribute to the cost of providing care to others in return for obtaining that contribution from others when they need care – or over time – mitigating the risk of facing overwhelming costs at a particular time by substituting a lower, regular premium cost over a longer period. The decision to regulate health insurance is not based on any normative view about the benefits of medical care for any particular person.

2. Other legislation mandates access to a minimum level of health care for all who seek it, even those who cannot pay

[24] Bucks et al., *supra*, n.18, at A27. This study reports that the median value of the direct and indirect stock holdings of all families with income below the 90th percentile was $62,000 in 2007. Indirect stock holdings include pooled investment trusts, retirement accounts, and other managed accounts.

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Existing federal legislation requires care to be provided to the very sick, even if they cannot pay for it. The Emergency Medical Treatment and Labor Act ("EMTALA")[25] mandates that hospitals that take Medicare, and virtually all do, to stabilize patients who come to their emergency rooms with emergency conditions even if they cannot pay for the care they need. Long before EMTALA, most hospitals provided this charity care as part of their mission.[26] This tradition of assuring the availability of some minimal level of treatment without regard to ability to pay reflects a collective decision that we, as a nation, are generally unwilling to see others come to great harm from the inability to pay for medical care.

There are many other unique attributes of health care that justify – indeed require – restrictions on private actors in the health care system. Because medical care is not an ordinary commodity, physicians owe their patients a duty[27] to provide care and are not free to contract over the terms of treatment in the same

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[25] 42 U.S.C. § 1395dd.

[26] Rosemary Stevens, In Sickness and in Wealth: American Hospitals in the Twentieth Century (Johns Hopkins Univ. Press 1999); Charles Rosenberg, The Care of Strangers: The Rise of America's Hospital System, (Johns Hopkins Univ. Press 1995); David Rosner, A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York 1885-1915 (Cambridge Univ. Press 1982).

[27] *See* Jill R. Horwitz, *The Multiple Common Law Roots of Charitable Immunity: An Essay in Honor of Richard Epstein's Contributions to Tort Law*, J. Tort L., Jan. 2010, at 29-33.

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manner as other buyers and sellers.[28] For example, medical care providers must ensure that their patients are informed before they give consent to their treatment. Additionally, physicians are bound under a common law duty not to abandon their patients once a physician-patient relationship is established. The physician has an obligation to provide care throughout an episode of illness and may not terminate the relationship unless specific restrictive conditions are met, such as when the patient either dismisses the physician or the physician gives the patient sufficient notice and opportunity to find alternate, sufficient treatment. [29] These requirements for severing the physician-patient relationship apply even if the patient cannot pay for his care.[30]

The obligation to provide medical care without regard to ability to pay necessarily imposes costs that must be borne by others, either through taxes or

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[28] *See, e.g., Tunkl v. Regents of Univ. of California*, 383 P.2d 441 (Cal. 1963) (finding that even though a patient may understand the significance of a contract releasing a hospital from potential liability in exchange for medical care, hospitals may not benefit from these exculpatory clauses because of the special way in which health care affects the public interest).

[29] *See, e.g., Saunders v. Lischkoff,* 188 So. 815, 819 (Fla. 1939) (noting that the obligation of continuing treatment can only be terminated "by the cessation of the necessity which gave rise to the relation of physician and patient, or by the discharge of the physician by the patient, or by the physician's withdrawing from the case, after giving the proper notice."); *accord, e.g., Lewis v. Capalbo,* 280 A.D.2d 257 (N.Y. App. Div. 2001); *Magana v. Elie,* 439 N.E.2d 1319 (Ill. 1982).

[30] *See, e.g., Ricks v. Budge*, 64 P.2d 208 (Utah 1937) (finding that the doctor did not give sufficient notice to allow his patient to procure other medical attention).

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through cost shifting that increases the costs to those who are able to pay, whether personally or through insurance. Economists variously term these induced costs an externality (a situation where one person's actions or inactions affects others), a free-rider problem (where people obtain a good and leave the costs to others), or a Samaritan's dilemma (where people choose not to prepare for emergencies, knowing that others will care for them if needed). Even basic economics textbooks stress that externalities require government intervention to improve the functioning of the market.[31]

3. Whether one person buys health insurance has cost implications for everyone else

Economists recognize the importance of the time dimension to individual decision-making. For most goods and services, the moment of purchase is different from the moment of consumption (purchase almost always precedes consumption). Thus, the decision to forgo insurance cannot be separated from the consequences of being without insurance, and no economic model treats them as separate. The consequences are three-fold. First, the decision not to purchase insurance may be followed by illness, requiring medical care financed by others. Second, people may forgo preventive care while uninsured (such as a mammogram or colonoscopy) and as a result require more care later (for example, when

[31] N. Gregory Mankiw, *supra* n.13.

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diagnosed with advanced cancer). Third, people may only receive partial care when they are uninsured and sick, and then use more care when they become insured.

In each of these circumstances, uninsured persons impose costs on others, even if one does not seek medical care in the onset of an illness. Consequently, the lack of health insurance has real and significant consequences for interstate commerce that are appreciably different than any impact resulting from other decisions to forego goods or types of insurance. Because health care providers are required to care for the sick regardless of whether they have insurance or the means to pay, and because medical care is so expensive, particularly for serious illnesses, the cost of people choosing to forgo coverage is necessarily shared with others. The medical care used by each uninsured person costs about $2,000 per year, on average.[32] Only 35 to 38 percent of this total is paid for by the uninsured

[32] The *Amici* Economists argue that the targets of the mandate, those between 18 and 34 who are healthy and do not have health insurance, spent only $854 on average for health care in 2010 and only $56 per year on average in total emergency room care. Amici Br., *supra* n.7, at 13-14. That argument suffers from several defects. First, the "targets" of the individual mandate are not limited to the healthy under 34. Many over the age of 34 have elected not to purchase insurance. They include, *inter alia*, those who were eligible for an employer-provided plan but decided to not to purchase the insurance and those for whom health insurance is too costly either because (i) they are ineligible to participate in an employer program or (ii) the insurance costs, including only catastrophe coverage, on the open market was beyond their means. For example, in 2008, the average non-group policy for individuals aged 30-34 cost $2,104 and $4,512 for families. AHIP

Footnote continued on next page

directly in out-of-pocket payments.[33] This is not true of the other necessities, including food, water, and clothing.

The remainder is financed in several ways. Thirty-two percent of the total is paid for by providers charging higher prices to the insured, as providers "cost shift" [34] from the uninsured to the insured. The total amount of cost shifting is over $40 billion per year, and the resulting increase in private insurance premiums has been estimated at between 1.7 percent[35] and 8.7 percent.[36] Another 14 percent of

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Footnote continued from previous page

Ctr. for Policy and Research, Individual Health Insurance (Oct. 2009), *available at* www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf; U.S. Census Bureau, *People Without Health Insurance Coverage by Selected Characteristics: 2008 and 2009* tbl. 8, *available at* http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2009/tab8.pdf.

Second, the average spent on health care or for an emergency room visit in a year ignores the *actual costs to the individual* who requires care. During 2008, the average costs for individuals who visited an emergency room was $1,203 and for those who were hospitalized, the hospital cost was $7,921. *See* AHQR Tables, *supra* n.15, at tbl. 5 (Hospital Inpatient Services-Median and Mean Expenses per Person with Expense and Distribution of Expenses by Source of Payment (2008)), *available at* http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=1&subcomponent=0&tableSeries=1&year=-1&SearchMethod=1&Action=Search.

[33] AHQR Tables, *supra* n.15; Jack Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, Health Affairs, Aug. 25, 2008, at w399-w415.

[34] Hadley et al., *supra* n.33.

[35] *Id.*

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the costs of the uninsured are paid for by government, through Medicare and Medicaid payments, and the VA, TriCare (medical insurance for military personnel and dependents), and workers' compensation. Higher government costs attributable to the uninsured are implicitly paid for by the insured as well, through increased taxes or reductions in other government services as money is spent on the uninsured. Finally, the remaining costs are generally either borne by the health-care providers or covered by philanthropic contributions.

Moreover, even people who can avoid using medical care when they are uninsured affect the amount paid by others in two ways. First, when some, relatively healthier people, refrain from buying health insurance, that raises the premiums of those who are insured, a phenomenon termed "adverse selection." Second, when people who were previously uninsured for a period of time obtain coverage, they tend to consume more care, resulting in greater costs to the system. They often have delayed seeking primary, preventive, and chronic care and thus become sicker over time.[37] When acute illness occurs, they may be insured through public or private insurance, thus increasing the amount that those

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Footnote continued from previous page

[36] Families USA, Paying a Premium: The Added Cost of Care for the Uninsured 35 (June 2005), *available at* www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf.

[37] Comm'n on the Consequences of Uninsurance, Inst. of Medicine, Health Insurance is a Family Matter 106 (2002).

programs spend. For example, Medicare beneficiaries who were uninsured prior to becoming eligible for Medicare used 51 percent more services than those who were insured prior to Medicare eligibility.[38] These costs are largely paid for by people who are insured, who pay higher taxes for Medicare when they are working, pay higher premiums for Part B coverage when they are enrolled in Medicare, or receive fewer government services because of the higher cost of Medicare.

Adverse selection causes health insurance premiums to increase due to a smaller and less healthy pool of insured persons. The increased premiums also cause additional people – many of whom are healthy – to opt out of the market, raising prices even higher. The end result of this process of individuals opting-out or waiting to purchase health insurance will be significantly lower coverage, and possibly an unraveling of the market as a whole, what is widely termed an adverse selection "death spiral."[39] In most states, insurers attempt to counter adverse selection by discriminating against the ill, through denials of coverage or exclusion of pre-existing conditions. These responses prevent those most in need from accessing the cost-spreading benefits of insurance, thus defeating a fundamental

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[38] J. Michael McWilliams et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries*, New Eng. J. Med., July 12, 2007, at 143-153.

[39] David M. Cutler and Sarah Reber, *Paying for Health Insurance: The Trade-off between Competition and Adverse Selection*, Q. J. of Econ., May 1998, at 433-466.

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purpose of insurance and further compounding the problem of uncompensated care.

Unfortunately, simply removing these tools from the reach of insurance companies does not solve the problem; insurers respond by raising prices for all market participants to offset their losses from selling to the sick. Several states have tried mandating coverage of individuals with pre-existing conditions, non-discrimination in insurance pricing, and other similar reforms of their markets for individuals' policies, without the equivalent of a minimum coverage requirement. All of these experiments failed, and the states that tried them are now among the most expensive places to buy non-group insurance.[40] The only economic solution to this dilemma is to ensure universal participation in insurance pools. The minimum coverage requirement is a reasonable way to do this.

II. Upholding Section 1501 Will Not Give Congress Unfettered Power to Impose New Mandates on Individuals

The unique characteristics of health care described in the preceding section also demonstrate why upholding the minimum coverage provision will not lead to equivalent federal interventions in other markets. The combination of the unavoidable need for medical care; the unpredictability of such need; the high cost of care, which frequently far outstrips an individual's or family's ability to pay; the

[40] Jonathan Gruber and Sara Rosenbaum, *Buying Health Care, The Individual Mandate, and the Constitution*, New Eng. J. Med., July 29, 2010, at 401-03.

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fact that providers cannot refuse to provide care in emergency situations, and generally will not in many other situations; and the very significant cost-shifting that underlies the way medical care is paid for in this country, combine to create a set of conditions and needs that do not exist in other contexts.[41]

While there are other necessities of life, they do not share the economic characteristics of health care. Because the need for such items is relatively certain in amount and time, people do not insure against the risk of not having food or shelter. Rather, they plan for those needs, even when their means are limited. Nor are grocery stores or landlords required to provide free food or housing to the impecunious. So too, while many families purchase homes, purchasing a home is a discretionary decision as living quarters can be rented.

By contrast, virtually all will require health care at some point, medical providers are obligated to provide care, and the costs of much medical care – especially the most-costly care – occur unpredictably. These expenses cannot be deferred nor can care be provided in other ways. Rather, the costs incurred by the uninsured are largely borne by others.

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[41] In *Florida v. HHS*, the court found that health care was not unique and that other markets shared some of these characteristics. 2011 WL 3519178, Nos. 11-11021 & 11-11067, at *51-63 (11th Cir. Aug. 12, 2011). However, the court focused on these characteristics separately rather than in combination. *Id*. And, in none of those markets must service be provided to those who cannot pay. *Id*.

Similarly, Appellants' attempt to equate health insurance with other forms of insurance, such as burial, life, supplemental income, credit, mortgage guarantee, etc.,[42] is unavailing. Each of those forms of insurance involves risk-spreading, but none deals with the combination of unavoidable need, unpredictable need, unpredictable costs, the obligation to provide service, and the cost shifting that characterizes the health care market. Several provide coverage for risks that may not occur, *e.g.*, mortgage guarantee insurance, and others are a form of savings account, *e.g.* burial insurance, or a timing bet with an insurance company, *e.g.* term life. The health care market is unique in its scope and characteristics, and none of the parallels Appellants and others have attempted to draw with other markets withstands analysis.

Congress enacted ACA to address failures in the health care insurance market that make it prohibitively difficult for many individuals to afford or obtain health insurance and produce escalating health care costs for consumers and taxpayers.[43] The decision to require most individuals who can afford it to obtain health insurance is a reasonable approach, as a matter of economics, to satisfying the Congress's objectives in reforming health insurance and creating a fairer and

[42] Appellants Br. at 57; *see also Florida v. HHS*, 2011 WL 3519178, Nos. 11-11021 & 11-11067, at *52.

[43] *See Liberty Univ., Inc.*, 753 F. Supp. 2d at 633; *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 894-95 (E.D. Mich. 2010) ("*Thomas More Law Ctr. I*").

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more efficient health care system.[44] The economic characteristics and principles that underlie this conclusion are not common to other markets. None involves the unavoidable need, the unpredictability, the high costs, the inability of providers to refuse to provide treatment, and the very significant cost-shifting that underlies the way medical care is paid for in this country. Section 1501 is a measured response to these unique characteristics of the health care market. Upholding that necessary corrective measure will not open the floodgates of unfettered federal power to require individuals to purchase goods and services or engage in activity that may be good for them.

III. The Decision to Forgo Health Care Insurance Directly Affects Interstate Commerce

A. The Decision to Forgo Health Care Insurance Is Not a Passive Decision

Appellants argue that the decision to eschew health insurance is not subject to regulation under the Commerce Clause because it is "inactivity." However, a number of studies in health economics show that the decision to forgo purchasing health insurance is not a passive act attributable to the passage of time or inadvertence. Rather, it is a considered decision driven by economic factors. Those studies indicate that the decision whether to purchase health insurance or not

[44] *See* J. Gruber, Health Care Reform without the Individual Mandate, Ctr. for Am. Progress (Feb. 2011), *available at* http://www.americanprogress.org/issues/2011/02/gruber_mandate.html.

responds in a manner strongly predicted by models of forward-looking behavior, and thus that many individuals forgo insurance as a result of strategic thinking.

One finding supporting this view is that about one-quarter of the uninsured reject the offer of employer-sponsored insurance and remain uninsured, despite the significant subsidies that virtually all employers offer for employer-sponsored insurance.[45] Other studies show that individuals are more likely to remain uninsured when there are more sources of "uncompensated care" available, such as public hospitals or hospitals that have high uncompensated care spending; the availability of free care influences the decision to be covered.[46]

Strategic decision-making is also evidenced by studies showing that when public insurance is expanded to some family members, such as children, families will often drop insurance for all members of the family to take advantage of the partial coverage for children. This exposes the ineligible family members to being uninsured but leads to overall benefits for the family.[47] Finally, evidence from

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[45] Jonathan Gruber and Ebonya Washington, *Subsidies to Employee Health Insurance Premiums and the Health Insurance Market*, J. of Health Econ., Mar. 2005, at 253-76.

[46] Kevin N. Rask and Kimberly J. Rask, *Public Insurance Substituting for Private Insurance: New Evidence Regarding Public Hospitals, Uncompensated Care Funds, and Medicaid*, J. of Health Econ., Jan. 19, 2000.

[47] David Cutler and Jonathan Gruber, *The Effect of Expanding the Medicaid Program on Public Insurance, Private Insurance, and Redistribution,* Am. Econ. Review, May 1996, at 368-73.

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Massachusetts shows that, even under the insurance mandate there, some people signed up for insurance but terminated their coverage within a year. The individuals who dropped coverage were much sicker than the typical person in the market.[48] The costs of allowing people to opt in and out of coverage – the "adverse selection" – was estimated to increase insurance premiums by 0.5 to 1.5 percent, and ending this loophole – which Massachusetts has done – would lower costs for everyone in the market by 1.2 percent. These data demonstrate that forgoing health insurance is frequently not "inactivity," as Appellants maintain, but an affirmative, rational economic decision.

In *Thomas More Law Center II*, the Sixth Circuit recently recognized the logical incoherence of the activity/inactivity distinction when it comes to insuring against financial risk in the health care market.[49] As Judge Sutton explained in his controlling opinion:

> [n]o one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk. Each requires affirmative choices; one is no less active than the other; and both affect commerce.[50]

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[48] Dianna K. Welch & Kurt Giesa, Oliver Wyman, Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets 2-3 (June 2010), *available at* http://www.mass.gov/Eoca/docs/doi/Companies/adverse_selection_report.pdf.

[49] 2011 WL 255603, No. 10-2388, at *14, *29, *32-*33 (6th Cir. June 29, 2011) (2-1 decision).

[50] *Id.* at *29.

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In fact, starting with the basic premise that "inaction *is* action . . . when it comes to financial risk," Judge Sutton observed that "if done responsibly, [self-insuring] requires more action (affirmatively saving money on a regular basis and managing the assets over time) than [buying insurance] (writing a check once or twice a year or never writing one at all if the employer withholds the premium)."[51]

B. The Decision to Forgo Health Care Insurance Has a Material Impact on Interstate Commerce

The failure to purchase health insurance has a direct impact on interstate commerce. Those without medical insurance often ignore medical conditions at their earlier stages and incur significantly greater costs when they ultimately seek aid. So too, the decision to forgo some types of curative care can result in the need for costlier care in the future, after the patient obtains coverage. The collective effect of individual decisions not to purchase health insurance affects health insurance premiums, the coverage which insurance companies can provide at reasonable rates, and the extent to which the costs of caring for the uninsured are borne by others, including taxpayers. The total costs of uncompensated care in 2008 alone were at least $43 billion.[52]

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[51] *Id.*

[52] Congress used this figure, based on a Congressional Budget Office report, in enacting ACA. However, it may understate the actual uncompensated costs in 2008. *See* Hadley, *supra* n.33, at 403 (estimating the cost of total uncompensated care at $56 billion, of which $43 billion is the government portion.)

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The "*Amici* Economists" argued in *Florida v. HHS* that the real uncompensated cost is only $8 billion. They arrive at that reduced figure by arguing that certain categories of "uncompensated costs … will not be affected by the individual mandate… ."[53] Their analysis makes a number of errors in describing those costs, and ignores the interrelationship between the independent mandate and the insurance reforms adopted in the Act. Unfortunately, the Court in *Florida v. HHS* accepted much of this analysis, notwithstanding its fundamental flaws, and produced, in *Amici's* view, an erroneous result.[54]

1. The Amici Economists' Analysis is flawed

The *Amici* Economists' analysis contains at least the following errors:

a. It excludes all of the costs of uncompensated care provided to uninsured individuals with chronic conditions, asserted to amount to $8.7 billion. They argue that, because ACA will make health insurance more broadly available, those individuals will obtain insurance voluntarily. However, this argument presumes that all individuals with any chronic condition are uninsured solely because of a lack of availability, and ignores the likelihood that some in this group – especially given the *Amici* Economists' broad definition of chronic conditions

[53] Amici Br., *supra* n.7, at 11. While $8.1 billion is less than $43 billion, it is not a trivial sum.

[54] *Florida v. HHS*, 2011 WL 3519178, Nos. 11-11021 & 11-11067, at *55 (11th Cir. Aug. 12, 2011).

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(including asthma, arthritis and high blood pressure) – would choose to remain uninsured even in a reformed market. More importantly, the analysis presumes that market reforms required under ACA can be sustained in the absence of an individual coverage requirement. As discussed below, this is a highly questionable assumption.

b. It assumes that any uncompensated care used by those below 133 percent of the poverty line should be ignored since those individuals will be eligible for free Medicaid care. However, this claim mistakenly assumes that all of these individuals are *uninsured*, when, in fact, some have insurance. Moreover, it falsely assumes that everyone eligible for the expanded Medicaid would choose to accept its coverage. Since there are millions of low income individuals now eligible for free Medicaid coverage who do not sign up, that assumption is debatable. Facing a minimum coverage requirement, these individuals would likely be induced to sign up for Medicaid.

c. It improperly subtracts roughly $8.1 billion in uncompensated care allegedly attributable to "illegal aliens and other nonresidents" from the $43 billion in uncompensated costs. But the question in the Medical Expenditure Panel

Survey on which this analysis relies covers care used by all *non-citizens.*[55] As section 1501 includes anyone who is lawfully present in the United States,[56] the $8.1 billion includes lawful residents who are subject to the minimum coverage requirement.

d. It incorrectly excludes $3.3 billion of uncompensated care due to the insured who do not make their co-pays or other out-of-pocket expenses. However, the $43 billion includes only costs due to the uninsured, and the $3.3 billion in costs attributable to insured people is not part of the total.

In addition to these flaws, the analysis ignores the fact that the $43 billion figure reflects 2008 costs. Updating the uncompensated care amounts to account for health care inflation by the time of the mandate's implementation in 2014 would increase the total to perhaps $58 billion, assuming projections.[57] Given the rise of the uninsured since 2008, the likely figures may be even higher. Consequently, the *Amici* Economists' attempt to demonstrate that those subject to

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[55] Leighton Ku, *Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States*, Am. J. of Pub. Health, July 2009, at 1322-28.

[56] *See* 26 U.S.C. § 5000A(d).

[57] Ctrs. for Medicare and Medicaid Servs., National Health Expenditure Projections 2009-2019 (Sept. 2010), *available at* http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf .

the mandate, *i.e.*, those without health insurance who would respond only to the mandate, have little impact on health care costs is seriously flawed.

2. The Amici Economists Ignore the Importance of the Mandate to the Insurance Reforms Adopted in the Act

More fundamentally, the *Amici* Economists' assertion that the $43 billion can be discounted because of coverage which the Act will make available ignores the interaction of the individual mandate and the guaranteed coverage and the community rating provisions of the Act. As discussed above, the decisions as to when and whether to acquire or drop coverage can affect whether these reforms can be maintained. Thus, for example, the collective effect of individual decisions to purchase insurance once a medical condition arises or on the way to the emergency room or to drop coverage once the condition is resolved, could lead to the "death spiral" discussed above: healthy people drop out of the market, insurance premiums rise, and more people are induced to drop coverage.

One goal of the mandate, as explicitly recognized section 1501(a)(2)(I), is to "broaden the health risk pool" in order to minimize the chances of such unraveling.[58] This is not purely a theoretical possibility: As noted above, the few

[58] Studies of the Massachusetts experience indicates that the mandate actually encourages healthier individuals to purchase insurance. Amitabh Chandra et al., *The Importance of the Individual Mandates -- Evidence from Massachusetts*, N. Engl. J. Med., Jan. 27, 2011, at 293-95, *available at* http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.

states that experimented with insurance market reforms of this type without a mandate saw the unraveling of their non-group markets and skyrocketing premiums. Consequently, the validity of the *Amici* Economists' analysis, even assuming *arguendo* that their numbers are correct, turns on the continued availability of the insurance market reforms in the Act. Without the mandate, those reforms may not be sustainable, leaving millions reliant on uncompensated care for their health care needs.[59]

CONCLUSION

For the reasons set forth above, *Amici* urge the Court, if it reaches the merits, to uphold section 1501. Spreading the costs of medical care across the broad spectrum of the population that will require medical assistance is essential to reforming the health care system in the United States and achieving the legitimate goals of the Act. While the minimum coverage requirement may appear unique, it is, as an economic matter, consistent with other obligations imposed under the Commerce Clause. It regulates economic decisions that have a substantial impact on the national market for health care. Given the unique economic characteristics of health care, upholding this necessary corrective measure will not grant Congress

[59] Jonathan Gruber, *Health Care Reform Without the Mandate, Replacing the Individual Mandate would Significantly Erode Coverage Gains and Raise Premiums for Health Care Consumers*, Ctr. for Am. Progress, Feb. 9, 2011, *available at* http://www.americanprogress.org/issues/2011/02/pdf/gruber_mandate.pdf.

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unfettered federal power to require individuals to purchase goods and services, to engage in activity that may be good for them, or usurp the police powers of the States.

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed R. App. P. 32(a), I certify that the attached "Brief *Amici Curiae* of Economic Scholars in Support of Defendants-Appellees Supporting Affirmance" is proportionally faced, has a typeface of Times New Roman, 14 points, and contains 6,979 words. I relied on Microsoft Word's calculation feature for the word count. Under Eighth Circuit Rule 28A(h), I certify that this Brief has been scanned for viruses and is virus-free.

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CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of August 2011, I electronically filed the foregoing "Brief *Amici Curiae* of Economic Scholars in Support of Defendants-Appellees Supporting Affirmance" with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the CM/ECF system, which will cause the Brief to be served on registered counsel via the CM/ECF System.

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